CHAPTER I

GENERAL INFORMATION

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CHAPTER I
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INTRODUCTION

The Virginia Medicaid Provider Manual describes the role of the provider in the Virginia Medical Assistance Program (Medicaid). To provide a better understanding of the Medicaid Program, this manual explains Medicaid rules, regulations, procedures, and reimbursement and contains information to assist the provider in answering inquiries from Medicaid recipients.

The manual can also be an effective training and reference tool for provider administrative personnel, since it conveys basic information regarding the Medicaid Program, covered and non-covered services, and billing procedures. Proper use of the manual will result in a reduction of errors in claims filing and, consequently, will facilitate accurate and timely payment.

In addition to the Medicaid Program, other programs administered by the Department of Medical Assistance Services (DMAS) include the Family Access to Medical Insurance Security (FAMIS) program, the State and Local Hospitalization (SLH) program, and the Uninsured Medical Catastrophe Fund. If you have any questions concerning the Medicaid Program or any of the other programs listed above, please contact the provider "HELPLINE" at:

804-786-6273	Richmond Area
1-800-552-8627	All other areas

PROGRAM BACKGROUND

In 1965, Congress created the Medical Assistance Program as Title XIX of the Social Security Act, which provides for federal grants to the states for their individual Medical Assistance programs. Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965. This enactment is popularly called "Medicaid" but is officially entitled "Grants to States for Medical Assistance Programs." The purpose of Title XIX is to enable the states to provide medical assistance to eligible indigent persons and to help these individuals if their income and resources are insufficient to meet the costs of necessary medical services. Such persons include dependent children, the aged, the blind, the disabled, pregnant women, and needy children.

The Medicaid Program is a jointly administered federal/state program that provides payment for necessary medical services to eligible persons who are unable to pay for such services. Funding for the Program comes from both the federal and state governments. The amount of federal funds for each state is determined by the average per capita income

of the state as compared to other states.

Virginia's Medical Assistance Program was authorized by the General Assembly in 1966 and is administered by the Virginia Department of Medical Assistance Services (DMAS). The Code of Federal Regulations allows states flexibility in designing their own medical assistance programs within established guidelines. Virginia Medicaid's goal is to provide health and medical care for the Commonwealth's poor and needy citizens using the health care delivery system already in place within the state. In 2003, the Virginia General Assembly changed the name of the Medicaid program covering most children to FAMIS Plus. The change in name was intended to facilitate a coordinated program for children's health coverage including both the FAMIS and FAMIS Plus programs. All covered services and administrative processes for children covered by FAMIS Plus remain the same as in Medicaid. While the Virginia Medicaid Program is administered by DMAS, the eligibility determination process is performed by local departments of social services through an interagency agreement with the Virginia Department of Social Services. The *State Plan for Medical Assistance* for administering the Medicaid Program was developed under the guidance of the Advisory Committee on Medicare and Medicaid appointed by the Governor of the Commonwealth of Virginia. The State Plan is maintained through continued guidance from the Board of Medical Assistance Services, which approves amendments to the *State Plan for Medical Assistance* with policy support from the Governor's Advisory Committee on Medicare and Medicaid. Members of the Governor's Advisory Committee and the Board of Medical Assistance Services are appointed by the Governor.

Individuals originally became eligible for Medicaid because of their "categorical" relationship to two federal cash assistance programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, congressional mandates in the late 1980s resulted in dramatic changes in Medicaid eligibility provisions. Now individuals, in additional selected low-income groups, are eligible for Medicaid solely on the relationship of their incomes to the Federal Poverty Guidelines. New Federal Poverty Guidelines are published annually in the *Federal Register* and become effective upon publication.

Medicaid is a means-tested program. Applicants' income and other resources must be within program financial standards, and different standards apply to different population groups, with children and pregnant women, and to persons who are aged, blind, and disabled.

GENERAL SCOPE OF THE PROGRAM

The Medical Assistance Program (Medicaid) is designed to assist eligible recipients in securing medical care within the guidelines of specified State and federal regulations. Medicaid provides access to medically necessary services or procedures for eligible recipients. The determination of medical necessity may be made by the Utilization Review Committee in certain facilities, a peer review organization, DMAS professional staff or DMAS contractors.

Covered Services

The following services are provided, **with limitations** (certain of these limitations are set forth below), by the Virginia Medicaid Program:

- AIDS Waiver services - Individuals who are HIV+ and symptomatic and meet the criteria for a nursing facility or hospital level of care can be authorized to receive case management, personal care, private duty nursing, and respite care.
- Adult Care Residence Intensive Assisted Living Waiver services
- BabyCare - Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two
- Blood glucose monitors and test strips for pregnant women
- Case management services for high-risk pregnant women and children up to age 1 (as defined in the State Plan and subject to certain limitations)
- Christian Science sanatoria services
- Clinical psychology services
- Clinic services
- Community Mental Retardation Services
- Consumer directed personal attendant services
- Contraceptive capsules including the insertion and removal
- Contraceptive injections
- Dental services, limited to recipients under 21 years of age in fulfillment of the treatment required under the EPSDT Program
- Diabetic test strips
- Durable medical equipment and supplies
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) - For individuals under age 21, EPSDT must include the services listed below:
    - Screening services, which encompass all of the following services:
        - Comprehensive health and developmental history
        - Comprehensive, unclothed physical exam

- Appropriate immunizations according to age and health history
- Laboratory tests (including blood lead screening)
- Health education

- Home health services

- Eyeglasses for all recipients younger than 21 years of age according to medical necessity

- Dental services for individuals under 21 years of age

- Hearing services

- Inpatient psychiatric services for recipients under age 21

- Environmental investigations to determine the source of lead contamination for children with elevated blood lead levels.

- Other medically necessary diagnostic and treatment services identified in an EPSDT screening exam, not limited to those covered services included above

- Skilled nursing facilities for persons under 21 years of age

- Transplant procedures as defined in the section "transplant services"

- All states are required to offer EPSDT to all Medicaid-eligible individuals under age 21 to determine any physical and mental defects that they may have and to provide health care, treatment, and other measures to correct or ameliorate the defects or chronic conditions discovered. The services available under EPSDT are not limited to those available in the Medicaid *State Plan for Medical Assistance*. Services requiring preauthorization under the *State Plan for Medical Assistance* will continue to require pre-authorization. DMAS reserves the right to utilize medical necessity criteria for non-State Plan services under EPSDT.

- Elderly and Disabled Waiver services - Individuals who meet the criteria for a nursing facility level of care can be authorized to receive adult day health care, personal care, and respite care.

- Emergency hospital services

- Emergency services for aliens

- Enteral nutrition (EN) - Coverage is limited to circumstances in which the nutritional supplement is the sole source of nutrition except for individuals authorized through the Technology-Assisted or AIDS Waiver or through EPSDT, is administered orally or through a nasogastric or gastrostomy tube,

and is necessary to treat a medical condition. Coverage of oral administration does NOT include the provision of routine infant formula.

- Extended services for pregnant women, pregnancy-related and postpartum services for 60 days after the pregnancy ends (limitations applicable to all covered services apply to this group as to all other recipient groups)
- Eye refractions
- Family planning services and supplies (for individuals of child-bearing age)
- Family Planning Waiver Services – women who are less than 24 months post-partum and whose deliveries were eligible for coverage by Medicaid and who continue to meet Family Planning Waiver eligibility criteria can be authorized to receive family planning services excluding anything related to abortions, fertility treatments, and hysterectomies up to 24 months postpartum.
- Federally Qualified Health Center services
- Home and Community-Based Care Waiver services
- Home health services
- Hospice services for individuals certified as terminally ill (defined as having a medical prognosis that life expectancy is six months or less)
- Inpatient care hospital services
- Inpatient Psychiatric Hospital Services for Individuals under 21 years of age (medically needy are not covered)
- Intensive rehabilitation services
- Intermediate care facility – Mental Retardation Services (medically needy recipients are not covered)
- Laboratory and radiograph services
- Legend drugs are covered with some limitations or exclusions. (See the Pharmacy Manual for specific limitations and requirements)
- Mental health, with limitations, covered under mental health and mental retardation community services
    - Mental Health:
        - Crisis stabilization
        - Mental health support
        - Intensive community treatment

- Intensive in-home services for children and adolescents
- Therapeutic day treatment for children and adolescents
- Day treatment/partial hospitalization
- Psychosocial rehabilitation
- Crisis intervention
- Case management

- Substance Abuse Services:

  - Residential treatment for pregnant and postpartum women
  - Day treatment for pregnant and postpartum women

- Mental Retardation Community Services Waiver:

  - Residential support services
  - Day support services
  - Habilitation services
  - Therapeutic consultation
  - Supported employment
  - Environmental modifications
  - Assistive technology
  - Nursing services
  - Personal assistance
  - Respite care
  - Crisis stabilization
  - Crisis supervision

- Mental Hospital Services for the Aged (65 Years and Older)
- Nurse-midwife services
- Nursing facility services
- Occupational therapy
- "Organ and disease" panel test procedures for blood chemistry tests
- Optometry services
- Outpatient hospital services
- Over-the-counter alternatives to certain classes of legend drugs. Upon a doctor's prescription or order, a pharmacy may provide and Medicaid will cover a drug that no longer requires a prescription to dispense. See the Pharmacy Manual for specific limitations and requirements.
- Papanicolau smear (Pap) test

- Payment of deductible and coinsurance up to the Medicaid limit less any applicable payments for health care benefits paid in part by Title XVIII (Medicare) for services covered by Medicaid
- Physical therapy and related rehabilitative services
- Physician services
- Podiatry services
- Prostate specific antigen (PSA) test (1998)
- Prostheses limited to artificial arms, legs, and the items necessary for attaching the prostheses, which must be pre-authorized by the DMAS central office. Also breast prostheses for any medically necessary reason and ocular prostheses for reason for loss of eyeball regardless of age of the recipient or the cause of the loss of the eyeball.
- Psychological testing for persons with mental retardation as part of the evaluation prior to admission to a nursing facility (January 1, 1989)
- Reconstructive surgery - post-mastectomy (1998)
- Rehabilitation services (physical therapy – effective 1969; other rehabilitation services – effective 1986)
- Renal dialysis clinic services
- Routine exams and immunizations for foster care children (EPSDT is not required)
- Rural Health Clinic services
- School-based services
- Services for individuals age 65 and older in institutions for mental diseases
- Specialized nursing facility services
- Speech-language therapy services
- Technology-assisted waiver services - Individuals under the age of 21 who require both a medical device and ongoing medical care to avert death or disability can be authorized to receive private duty nursing and respite care.
- Telemedicine for selected services - limited to certain types of providers.
- Transplant services: kidney and corneal transplants, heart, lung, and liver

transplants, without age limits; under EPSDT, liver, heart, lung, small bowel and bone marrow transplants and any other medically necessary transplant procedures that are not experimental or investigational, limited to persons under 21 years of age. Coverage of bone marrow transplants for individuals over 21 years of age is allowed for a diagnosis of lymphoma or breast cancer, leukemia, or myeloma.

- Transportation services related to medical care
- Treatment Foster Care Case Management

General Exclusions

Payment cannot be made under the Medicaid Program for certain items and services, and Virginia Medicaid will not reimburse providers for these non-covered services. Recipients have been advised that they may be responsible for payment to providers for non-covered services. Prior to the provision of the service, the provider must advise the recipient that he or she may be billed for the non-covered service. The provider may not bill the recipient for missed or broken appointments, which includes transportation services arranged by the recipient who is not at the pickup point or declines to get into the vehicle when the provider arrives.

Examples of such non-covered services are as follows:

- Abortions, except when the life or health of the mother is substantially endangered
- Acupuncture
- Artificial insemination or in vitro fertilization
- Autopsy examinations
- Cosmetic surgery
- Courtesy calls - visits in which no identifiable medical service was rendered
- Custodial care
- Dental services for recipients 21 years of age and over, except for limited oral surgery covered as defined by Title XVIII (Medicare) and by DMAS for all recipients
- DESI drugs (drugs considered to be less than effective by the Food and Drug Administration)
- Domestic services (except for those approved as part of personal care services or homemaker services under BabyCare or EPSDT

- Experimental medical or surgical procedures
- Eyeglass services for recipients age 21 and over
- Fertility Services - Services to promote fertility are not covered. However, if there is a disease of the reproductive system that requires treatment to maintain overall health, the medical procedure will be covered
- Free services - Services provided free to the general public cannot be billed to Medicaid; this exclusion does not apply where items and services are furnished to an indigent individual without charge because of his or her inability to pay, provided the provider, physician, or supplier bills other patients to the extent that they are able to pay
- Interpreter services for recipients who are deaf or hard of hearing
- Items or services covered under a workers' compensation law or other payment sources
- Meals-on-Wheels or similar food service arrangements and domestic housekeeping services which are unrelated to patient care
- Medical care provided by mail or telephone
- Medical care provided in freestanding psychiatric hospitals except through EPSDT
- Personal comfort items
- Physician hospital services for non-covered hospital stays
- Preventive medical care – Other than preventive care services provided under EPSDT and screening mammograms, pap smears, screening for colorectal cancer and PSA tests. Preventive care such as routine physicals and immunizations, well-child examinations, preschool examinations, camp physicals, and work permit examinations are not covered. Routine exams and immunizations for foster children are covered when arranged by the appropriate local Department of Social Services.
- Private duty nursing services – Other than for children and adults under the appropriate waiver
- Procedures prohibited by State or federal statute or regulations
- Prostheses (other than limbs, and the items necessary for attaching them, and breast prostheses)
- Psychological testing done for purposes of educational diagnosis or school

admission or placement

- Rehabilitative treatment of substance abuse
- Routine foot care
- Screening services: Exceptions: Pap smears and mammograms are covered for women over 30. Screening services for colorectal cancer are covered according to medical guidelines, and also PSA tests.
- Services determined not to be reasonable and/or medically necessary
- Services to persons under age 65 in mental hospitals (except under the EPSDT coverage)
- Smoking cessation programs
- Sterilizations when the patient is under age 21 or legally incompetent
- Supplies and equipment for personal comfort, such as adult diapers except when provided as durable medical equipment, "Lifecall" systems, and air cleaners
- Transsexual surgery
- Unkept or broken appointments
- Unoccupied nursing facility beds except for therapeutic leave days for nursing facility patients
- Weight loss programs

RECIPIENT COPAYS

Copays are the same for categorically needy recipients, Qualified Medicare Beneficiaries (QMBs), and medically needy recipients. Copays and their amounts are:

SERVICE	COPAY AMOUNT
Inpatient Hospital	$100.00 per admission
Outpatient hospital clinic	3.00 per visit
Clinic visit	1.00 per visit
Physician office visit	1.00 per visit
Other Physician service	3.00 per service
Eye examination	1.00 per examination
Prescription	1.00 per prescription (generic) 3.00 per prescription (brand-name) (effective July 1, 2003)

Home health visit	3.00 per visit
Rehabilitation therapy services (PT, OT, Speech/Language) service	3.00 per service

For purposes of copays, a visit is defined as a patient encounter in the same place of treatment, by the same provider on the same day regardless of the number of procedures performed. The encounter may be direct or indirect.

Special Indicator Code (Copayment Code)

The Special Indicator Code indicates the status of copayments or eligibility for certain additional services. After July 2003, providers will be notified of the recipient's copayment status as a part of eligibility verification. These codes are:

Code	Message
A	Under 21 - No copay exists.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care - No copay is required for any service.
C	All Other Clients - Copays apply for inpatient hospital admissions, outpatient hospital clinic visits, clinic visits, physician office visits, other physician visits, eye examinations, prescriptions, home health visits, and rehabilitation service visits. (Some verification methods may return a yes/no response. Yes = copays apply. No = copays do not apply)

The following copay exemptions apply:

- Enrollees in managed care organizations may not have to pay copays.
- Pregnancy-related services or family planning clinic visits, drugs, and supplies are exempt from copays for all clients.
- No copayments apply for any emergency services for any client, with one exception for clients in Client Medical Management with a pharmacy restriction. Please refer to the Client Medical Management exhibit in Chapter 1 for more information on this exception.

Services to a recipient cannot be denied solely because of his or her inability to pay an applicable copayment charge. This does not relieve the recipient of the responsibility to pay nor does it prevent the provider from attempting to collect any applicable copayment from the recipient.

MEDICAL COVERAGE FOR SPECIFIED ALIENS

Section 1903v of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for specified aliens when these services are provided in a hospital emergency room or inpatient hospital setting. (See Chapter III for details on eligibility.)

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks
- Traumatic injuries
- Childbirth
- Acute coronary difficulties
- Emergency surgeries (i.e., appendectomies)
- Episodes of acute pain (etiology unknown)
- Acute infectious processes requiring intravenous antibiotics
- Fractures

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care
- Physician services
- Inpatient hospitalization not to exceed limits established for other Medicaid recipients
- Ambulance service to the emergency room or hospital
- Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are not included in the covered services.

CLIENT MEDICAL MANAGEMENT (CMM)

The Client Medical Management Program (CMM) for recipients and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM recipient and provider restriction procedures is established through federal regulations in 42 CFR 431.54(e-f) and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30-130-820. (See the "Exhibits" section at the end of this chapter for detailed information on the CMM Program.)

Providers may refer Medicaid patients suspected of inappropriately using or abusing Medicaid services to DMAS's Recipient Monitoring Unit. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program.

Referrals may be made by telephone or in writing. The number for the Recipient Monitoring Unit is (804) 786-6548 or toll-free (888) 323-0589. Referrals can also be faxed

to (804) 371-8891. Office hours are 8:15 a.m. – 5:00 p.m., Monday through Friday except state holidays. Voice mail receives after-hours referrals.

Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Section
Division of Cost Settlement and Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

When making a referral, provide the recipient's name and Medicaid number and a brief statement regarding the nature of the utilization problems. Copies of pertinent documentation, such as emergency records, would be helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

MANAGED CARE PROGRAMS

The Virginia Department of Medical Assistance Services (DMAS) provides Medicaid to individuals through three programs. Fee-for-Service (FFS) is the standard Medicaid program and there are two managed care programs: MEDALLION and Medallion II. The MEDALLION program is administered by DMAS. MEDALLION is a Primary Care Case Management (PCCM) program and operates as the sole managed care program in 33 localities throughout the state. Enrollees in the specified eligibility categories who live in these localities must enroll in the MEDALLION program and seek their services through a contracted primary care case manager (PCP). Medallion II is a program that operates in 70 localities throughout the state. Enrollees in the specified eligibility categories in Medallion II localities must enroll with one of the Medicaid-contracted managed care organizations (MCOs) available in those localities. Enrollees who live in an area where both the MEDALLION and Medallion II programs operate simultaneously, of which there are 33 within the State, can choose under which managed care program they wish to participate.

Participation in a managed care program is mandatory for Medicaid enrollees in specified eligibility categories including, but not limited to, Low-Income Families and Children, Medically Indigent and SSI populations. Clients are excluded from managed care participation when they meet one of the exclusion criteria found in 12 VAC 30-20-170 (Medallion II), or 12 VAC 30-120-280 (MEDALLION). The exclusion reasons are listed below. Many of these reasons are the same for both programs, however, items specific to the Medallion II program are indicated with an asterisk (*).

- Individuals with Medicare coverage or other comprehensive health insurance coverage;

- Foster-care children, subsidized adoptions;

- Individuals with a Medicaid spend-down requirement;

- Individuals approved by DMAS as inpatients in nursing facilities, state mental institutions, long-stay hospitals, or intermediate care facilities for the mentally retarded;

- *Individuals who enter into a hospice program in accordance with DMAS criteria;

- *Individuals pre-assigned to a MCO but who have not yet been enrolled, who are inpatients in hospitals other than those listed above, at the scheduled time of enrollment, or who are scheduled for surgery that requires an inpatient hospital stay within 30 calendar days of the enrollment effective date. The exclusion shall remain in effect until the first day of the month following discharge;

- *Individuals participating in federal waiver programs for family planning and home and community-based Medicaid coverage;

- *Newly eligible individuals in their third trimester of pregnancy, who request exclusion within the first 15 days of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with any of the State-contracted MCOs. Exclusion requests made during the third trimester may be made by the recipient, MCO or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid;

- *Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO;

- *Individuals pre-assigned to an MCO but who have not yet enrolled, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less, if they request exclusion. The client's physician must certify life expectancy;

- *Certain individuals between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Ace (20 USC §1471 et seq.) who are granted an exception by DMAS to the mandatory Medallion II enrollment;

- *Individuals who have an eligibility period that is only retroactive;

- *Individuals under age 21 who are enrolled in DMAS authorized residential treatment or treatment foster care programs.

Individuals enrolled with a MCO that subsequently meet one or more of these criteria during MCO enrollment will be disenrolled as appropriate by DMAS.

Individuals excluded from mandatory managed care enrollment will receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they will be required to enroll in the appropriate managed care program.

MEDALLION

MEDALLION is a mandatory Primary Care Case Management program in which Medicaid recipients select their personal Primary Care Physicians (PCPs) who are responsible for providing and/or coordinating the services necessary to meet all of their health care needs. MEDALLION promotes physician/patient relationships, preventive care, and patient education while reducing the inappropriate use of medical services.

The MEDALLION PCP is a Medicaid provider who agrees to sign and adhere to an addendum to the Medicaid provider agreement to provide coordinated care for a monthly case management fee. The MEDALLION PCP provides 24-hour a day and 7 day a week access and focuses on preventive health care services including EPSDT and BabyCare. The MEDALLION PCP serves as a manager for access to most other non-emergency services that the MEDALLION PCP is unable to deliver through the normal practice of primary care medicine. The MEDALLION PCP must provide a referral for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered.

To provide specialty services to a MEDALLION recipient, a referral from the recipient's MEDALLION PCP is required. Before rendering services, either direct the patient back to his or her MEDALLION PCP to request a referral or contact the MEDALLION PCP to inquire whether a referral is forthcoming. Refer to the MEDALLION supplement to this manual for further details on the program.

MEDALLION II

Medallion II enrollees receive primary and acute care services through mandatory enrollment in a managed care organization (MCO). Medallion II first began January 1, 1996 in the Tidewater area (Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Poquoson, and Virginia Beach). On November 1, 1997, Medallion II expanded to the counties of York, James City, Gloucester, Isle of Wight, and the cities of Williamsburg and Suffolk. Effective April 1, 1999, Medallion II expanded again to Central Virginia (the Richmond metropolitan area), the Eastern Shore and Southwest Tidewater regions. On October 1, 2000, Medallion II moved into the Fredericksburg and Mecklenburg areas. The most recent and largest expansion was on December 1, 2001, which brought Medallion II into Northern Virginia, Charlottesville and surrounding areas, and Roanoke.

There are seven Medicaid-contracted MCOs in Virginia. They are: Virginia Premier Health Plan, Sentara Family Care, UNICARE Health Plan of Virginia, Southern

Health/CareNet, Anthem Healthkeepers Plus, Anthem Peninsula Health Care, and Anthem Priority Health Care. DMAS reimburses the health plans a monthly capitated fee for each enrollee. These fees are preset, and are determined by demographics such as patient's age, sex, program designation, and locality of residence. Each MCO is responsible for developing its own network of providers and for ensuring that its delivery system has an adequate number of facilities, locations, and personnel available and accessible to provide covered services for its enrollees. Providers who contract with a MCO must meet the MCO's contracting requirements.

Medicaid-contracted MCOs must provide all the services covered by Medicaid except for certain carved-out services. Covered services include but are not limited to, inpatient and outpatient hospital, physician, pharmacy, transportation, durable medical equipment, laboratory, and dental services. **While enrolled in a MCO, DMAS will NOT pay for services provided to MCO enrollees EXCEPT for services carved-out specifically from the MCO contracts.** These carved-out services are listed below. In these cases, the client remains enrolled in the MCO but the specific carved-out service is reimbursed by DMAS, if the service is appropriate and in compliance with State and Federal Medicaid rules. For non-MCO services, the recipient must present his or her plastic ID card. The carved-out services are:

- Community rehabilitation mental health services, mental retardation services, and substance abuse treatment services as set forth in 12 VAC 30-50-226 through 12 VAC 30-50-228.

- School-based services, mandated special education services, and those health screenings provided to Medicaid enrollees under school/community health services grants from the Department of Education, as set forth in 12 VAC 30-50-200.

- Targeted case management services provided to the elderly, to Auxiliary Grant enrollees in adult care residences, and to individuals receiving community mental health services and mental retardation services as set forth in 12 VAC 30-50-460 and 12 VAC 30-50-470.

- Investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of Medicaid-eligible children who have been diagnosed with elevated blood levels, as set forth in 12 VAC 30-50-220.

- Abortions as set forth in 12 VAC 30-50-180 and 42 CFR § 441.203 and §441.206.

The following services must be reimbursed by the MCO regardless of whether the provider is in or out of the MCO's network:

- Emergency and Post-Stabilization Services-an emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who

possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

- Family Planning services- the MCO shall cover all family planning services that include services and supplies for individuals of child-bearing age that delay or prevent pregnancy, but does not include services to treat infertility or to promote fertility.

Insurance coverage must be verified before treatment is provided. Medallion II clients will have a MCO identification card and a Medicaid card. Also, Medallion II clients and MCO providers must adhere to the MCO's requirements regarding referrals and prior authorizations. Providers who do not participate in the enrollee's MCO must inform the enrollee prior to the provision of service that the enrollee will be responsible for payment except in emergencies.

Failure to confirm Medicaid eligibility and insurance coverage can result in a denial of payment.

To verify eligibility, call the MCO's enrollment verification system or the DMAS MediCall line at 1-800-772-9996 or 1-800-884-9730 (outside of Richmond), or (804) 965-9732 or (804) 9733 for Richmond and the surrounding counties. Eligibility information is also available using the web-based Automated Response System (ARS). When using the DMAS MediCall line or the ARS system, MCO information, if applicable, follows Medicaid eligibility information.

The managed care programs focus on coordinated care, primary care case management, improving health outcomes, and improving provider access. Enrollees who have questions regarding the managed care programs can contact the Managed Care Helpline at 1-800-643-2273. Additional information on the programs can also be obtained through the DMAS website at www.dmas.state.va.us.

Continuity of Care

The Department attempts to make the transition between fee-for-service Medicaid and the MCO seamless whenever possible. As a result there is a process to ensure that the Medicaid information and authorization information is transferred and honored. In order to assure continuity of care for clients enrolled in MCOs, the following procedures are used:

- The Contractor (the enrollee's current MCO) shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the enrollment effective date, in the absence of a written agreement otherwise. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the Contractor (the enrollee's current MCO) shall continue prior authorized services without interruption

until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider.

- DMAS shall assume responsibility for all covered services authorized by the enrollee's previous MCO which are rendered after the effective date of disenrollment to the fee-for-service system, if the enrollee otherwise remains eligible for the service(s);

- If the prior authorized service is an inpatient stay, the financial responsibility shall be allocated between the enrollee's current MCO and either DMAS or the new MCO. In the absence of a written agreement otherwise, the enrollee's current MCO and DMAS or the new MCO shall each pay for the period during which the enrollee is enrolled with the entity. This also applies to newborns hospitalized at the time of enrollment.

- If services have been prior-authorized using a provider who is out of network, the enrollee's current MCO may elect to reauthorize (but not deny) those services using an in-network provider.

SOURCES OF INFORMATION

MediCall Automated Voice Response System

Toll-free numbers are available 24-hours-per-day, seven days a week, to confirm recipient eligibility status, claim status and check status. The numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification. Specific instructions on the use of the verification systems are included in "Exhibits" at the end of this chapter.

Automated Response System (ARS)

Providers may use the Internet to verify recipient eligibility and perform other inquiry functions. Inquiries can be submitted in real-time. Specific instructions on the use of the ARS are included in "Exhibits" at the end of this chapter.

HELPLINE

A toll-free "HELPLINE" is available to assist providers in interpreting Medicaid policy and procedures and in resolving problems with individual claims. The HELPLINE numbers are:

(804)786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll free)

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on State holidays.

The Virginia Medicaid provider number must accompany all provider inquiries (both written and via the HELPLINE). All provider information and data are filed by provider number. This number will expedite recovery of the requested information.

Do not use these HELPLINE numbers for recipient eligibility verification and eligibility questions. Local departments of social services are responsible for supplying information to recipients, and recipients who have questions about the Medicaid Program should be directed to their local departments of social services. If MediCall is not available, the data will also be unavailable to the HELPLINE (when the system is down).

The Medicaid HELPLINE and MediCall numbers are for provider use only and should not be given to recipients.

Home and Community-Based Care Services Information

Except for billing issues, all questions pertaining to the delivery of home and community-based care waiver services should be directed to WVMI, the DMAS contractor. The telephone numbers are:

(804) 648-3159	Richmond
1-800-299-9864	All Other Areas

Community-Based Care Services assistance is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on state holidays.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after October 15, 2003, and all local service codes will be ended for claims with dates of service after October 15, 2003. All claims submitted with dates of service after October 15, 2003 will be denied if local codes are used.

The Virginia MMIS will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of profession claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied)
- 270 & 271 for eligibility inquiry and response

- 278 for prior authorization request and response.

Although not mandated by HIPAA, DMAS has opted to produce an unsolicited 277 transaction to report information on pended claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: http://virginia.fhsc.com.

PROVIDER MANUAL UPDATES

This manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, revised pages or sections will be issued by the Department of Medical Assistance Services (DMAS) as needed.

Updates to this manual will be accompanied by an update transmittal memorandum. These updates will have an identifying code and sequential identification numbers assigned for each calendar year, e.g., H 1-99. The transmittal memorandum identifies the new page number(s) to be added and/or the page(s) to be replaced, and it will provide any other pertinent information regarding the update being made.

To be an effective tool, the manual must be properly maintained. Updates should be promptly filed, according to the following procedures:

An Update Control Log has been provided in the back of this manual. The transmittal log numbers run consecutively from 1-44. When an update package is received or downloaded and printed, put the updated pages in the appropriate place in the manual and enter the release date in the next blank space in the Update Control Log. The release date is the date of issue by DMAS. File the transmittal letter immediately after the Update Control Log. If the Update Control Log indicates missing transmittals, contact the HELPLINE to request copies of these transmittals, or download them from www.dmas.state.va.us. (See the section titled "Sources of Information.")

NOTICE OF PROVIDER RESPONSIBILITY

The provider is responsible for reading and adhering to the policies and regulations explained in this manual and for ensuring that all employees do likewise. The provider also certifies by his or her personal signature or the signature of an authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Satisfaction and payment of any claim will be from federal and State funds, and **any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or State laws.**

Providers have the right to appeal adverse actions. Time frames for completing cases remanded by DMAS hearing officers are established in accordance with the "reasonable promptness" standard of Title 42 C.F.R. §§ 431.220(a)(1) and 431.241. The time frames for the following entities are effective for decisions issued on and after February 16, 1996:

Local Department of Social Services	30 days
Local Health Departments	30 days
Department of Mental Health, Mental Retardation and Substance Abuse Services	30 days
Nursing Facilities	30 days
Medicaid Disability Unit	45 days
DMAS Divisions	30 days

Chapter II of this manual contains the details for the reconsideration of adverse actions.

EXHIBITS

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

The Virginia Medical Assistance MediCall System offers Medicaid providers twenty-four-hour-a-day, seven-day-a-week access to current enrollee eligibility information, check status, claims status, prior authorization information, service limit information, pharmacy prescriber identification number cross reference, and information to access enrollee eligibility and provider payment verification via the Internet. MediCall is an enhancement to the previous Medicaid Audio Verification Response System (AVRS).

Not only does MediCall offer providers flexibility in choosing the time of day for their inquiries, but it also makes efficient use of staff time. A valid provider number and a touch-tone telephone are required to access MediCall.

To reach an operator while using the enrollee eligibility verification feature of MediCall, key "0" at any prompt within the Enrollee Eligibility menu. Operator assisted calls are limited to three name searches per call. The operator will not be able to return the caller to MediCall for further inquiries. Operators are available from 8:30 a.m. to 4:30 p.m. Eastern time, Monday through Friday except for state holidays.

MediCall prompts the caller throughout the inquiry, giving and receiving only essential, pertinent information. The data provided is the most up-to-date information available, direct from the Medicaid eligibility, claims and remittance databases. If the caller waits too long to respond to a system prompt, the call will be disconnected.

System downtime will be scheduled during non-peak hours. If the caller dials MediCall during this time, the caller will be informed that the system is unavailable. System downtime is typically scheduled for:

2:00 a.m. to 4:00 a.m. Daily
2:00 a.m. to 6:30 a.m. Thursday
10:00 p.m. Saturday to 6:00 a.m. Sunday

The telephone numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

If you have any questions regarding the use of MediCall, contact the Medicaid Provider "HELPLINE." The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The HELPLINE numbers are:

1-804-786-6273	Richmond Area and out of state long distance
1-800-552-8627	In state long distance (toll-free)

HOW TO USE THE SYSTEM

To access MediCall, the provider must have a currently active Medicaid provider number. The provider's number is verified before access to MediCall is authorized.

Responses by the caller to MediCall are required within a specified period of time. If the time limit is exceeded, the call will be disconnected. The caller should have the following information available before calling:

- Virginia 9-digit Medicaid Provider Identification Number (For 7 digit provider numbers, add two leading zeros.)
- Enrollee Medicaid Number (12 digits) or Social Security Number (9 digits) **and** Date of Birth (8 digits) in month, day, century and year format (mmddyyyy) (necessary for enrollee eligibility verification and claims status)
- From and Thru Date(s) of Service in month, day, century and year format (mmddyyyy) (necessary for enrollee eligibility verification and claims status). The caller will have the following limits when entering dates of service:
    - The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the # key prompts the system to continue.
    - Future month information is only available in the last week of the current month.
    - Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

After dialing the MediCall number, the system will ask for the provider number. Enter the 9-digit number (using two leading zeros for 7 digit numbers). After the number is accepted, the menu will present seven options:

- Press "1" for enrollee eligibility verification.
- Press "2" for recent check amounts.
- Press "3" for claims status.
- Press "4" for prior authorization information.
- Press "5" for service limit information.
- Press "6" for pharmacy prescriber ID verification.
- Press "7" for information about Internet access to enrollee eligibility and provider payment verification.

ENROLLEE ELIGIBILITY VERIFICATION

Enter the From and Thru dates of service. **The service dates for enrollee eligibility verification cannot span more than 31 days.** When the dates of service have been entered, MediCall will verify the information and respond by speaking the first six letters of the last name and the enrollee's Medicaid number for confirmation.

Remain on the line to obtain important enrollee information that might affect payment, such as:

- Special Indicator Codes (Copayment)
- Client Medical Management Information Including Pharmacy/Physician

Telephone Number

- Medicare Eligibility
- Other Insurance Coverage
- Special Coverage (QMB, QMB--Extended)
- "MEDALLION" Participation
- Managed Care Organization provider name and assignment dates

At this point, MediCall will prompt the caller for the next action. The caller may ask for additional dates of service on this enrollee, or may inquire on another enrollee.

The caller may check up to **three** dates of service for each enrollee and inquire on up to **three** enrollees per call.

If the caller is using a Social Security Number instead of the enrollee ID number, the dates of service will relate to the first enrollee ID reported. If multiple open records exist for the same Social Security Number, you will be advised to contact the local department of social services. You will be given a 3-digit city/county code of the appropriate agency and a 5-digit caseworker code. A cross-reference list of the city/county codes is provided as an exhibit to this chapter.

The caller will receive a "not eligible" response if the future dates about which he or she inquires are beyond the information on file.

A response, "not eligible," will be given if the enrollee is not eligible for all days within the time span entered.

PROVIDER CHECK LOG

The most recent check information is presented by invoice type. This inquiry permits the provider to receive check dates and amounts from the most recent three remittances.

CLAIMS STATUS

For claims status information, the MediCall system will prompt the provider to choose the among the following invoice types (additional information in italics).

- For inpatient care, press 01.
- For long-term care, press 02.
- For outpatient hospital, home health or rehabilitation services, press 03.
- For personal care, press 04.
- For practitioner (physician CMS-1500 billing), press 05.
- For pharmacy, press 06.
- For independent labs (outpatient lab services), press 08.
- For Medicare crossover, press 09.

- For dental, press 11.
- For transportation, press 13.

For claims status, the From date cannot be more than 365 days in the past. The Thru date cannot be more than 31 days later than the From date. After keying the enrollee identification number and the From and Thru date(s) of service, MediCall will provide the status of each claim up to and including five claims. MediCall will prompt for any additional claims or return to the main menu.

PRIOR AUTHORIZATION INFORMATION

The From and Thru dates for prior authorization cannot span more than 365 days. When the 12-digit enrollee ID number and the 8-digit from and through dates of service have been entered, you will be prompted to enter the 11-digit prior authorization number, if known. If you do not know the prior authorization number, then press the pound (#) key. MediCall will verify prior authorization data on file. The system will prompt you to return additional prior authorization data for the same enrollee and dates, enter new dates for the same enrollee, another prior authorization number for the same enrollee or to enter another enrollee ID number to begin a new inquiry.

SERVICE LIMITS INFORMATION FOR PSYCHIATRIC PROVIDER TYPES

The psychiatric provider can inquire about the following service limits:

- For outpatient psychiatric, press 1.
- For substance abuse, press 2.
- For occupational therapy, press 3.
- For physical therapy, press 4
- For speech therapy, press 5.
- For home health aide, press 6.
- For home health skilled nursing, press 7.

SERVICE LIMITS INFORMATION FOR ALL OTHER PROVIDER TYPES

The provider can inquire about the following service limits:

- For occupational therapy, press 1.
- For physical therapy, press 2
- For speech therapy, press 3.
- For home health aide, press 4.
- For home health skilled nursing, press 5.

For occupational therapy, speech therapy or physical therapy the MediCall system will return non-school based and school based service limits separately.

PRESCRIBING PROVIDER ID

Only enrolled Pharmacy providers can access this choice. When prompted, the caller should enter the license number of the prescriber. MediCall will return the first six letters of the prescriber's last name and Medical Assistance provider number. If the prescriber is not active in Virginia Medicaid, you will receive a message that the number is not on file.

THE VIRGINIA MEDICAL ASSISTANCE AUTOMATED RESPONSE SYSTEM

GENERAL INFORMATION

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-four-hour-a-day, seven-day-a-week internet access to current enrollee eligibility information, service limits, claim status, prior authorizations, provider check status and prescribing provider ID lookup (for pharmacy providers only). This web-enabled tool helps provide cost-effective care for enrollees, and allows providers to access current information quickly and conveniently. Unlike MediCall (the voice response system), the user is not limited to a maximum number of inquires per session.

The ARS system is designed to be easy to use and will be accessible to anyone with an internet-connected PC and a web browser.

HOW TO USE THE SYSTEM

To access ARS, the provider must have a currently active Medicaid provider number. The provider's number is verified before access to ARS is authorized.

New users must register for ARS online at http://virginia.fhsc.com/. From the menu select "Automated Response System (ARS)" and then select "Secure Registration." Users must select "I Agree" after reading the privacy and security statements to access the registration page. Complete the registration form and select "Submit." Within 72 hours of registration, users will receive a phone call from First Health Services Corporation informing them of their logon name and password.

Questions about the registration process can be directed to:

(804) 270-5105	Richmond Area
1 (888) 829-5373	In-State Providers Only

Registered users select "Secure Logon" from the "Automated Response System (ARS)" menu to begin an inquiry.

1. Provider Logon Screen: The user enters the 9-digit servicing provider's Medicaid provider number with the prefix "VA," for example VA999999999. For 7-digit provider numbers, users should enter the prefix VA00, for example VA009999999. Click Submit to reach the menu.

If the provider number is inactive or invalid, an error message will appear.

2. Menu Screen: Once the provider ID has been accepted, the main menu screen will appear. Click on one of the five choices:

- Eligibility Benefit Verification and Services Limits (DDE 270/271)
- Claims Status Verification (DDE 276/277)
- Prior Authorization Log
- Provider Check Log
- Prescribing Provider ID Lookup*

This selection will advance the user to the search criteria screen for the specified transaction.

*Note: Only pharmacy providers have access to the Prescribing Provider ID lookup option. This option will only appear on the menu for those providers with a pharmacy provider ID.

3. Eligibility Benefit Verification and Services Limits Screen: Provider ID, entity type qualifier, and provider name will be populated and returned to the screen based on the provider ID entered in the Provider Logon screen. Enter the 12-digit enrollee number from the plastic ID card. Enter a "from" date of service in the mm, dd, yyyy format. Always enter both the "from" date of service and the "through" date of service, even if the span is a single day. Service "from" and "through" dates cannot exceed one month. The service "from" date must be within one year from the current date. Future service dates are not allowed.

If the enrollee ID is not known, two of the three identifiers are required to complete a verification/service limits transaction. These identifiers include:

- Exact name (middle name is optional)
- Social security number
- Date of birth

Unmatched entries will result in an error message.

Enter the provider's control or trace number. This can be a patient account number, a date and time, or any other alphanumeric code chosen by the provider to track this inquiry. This field will accept up to 30 characters.

A drop down box allows users to select the service type code for the inquiry.

Input/Response Screens

Eligibility Response Screen: The response contains available eligibility information for the person for whom the request was made. Information regarding Managed Care Organization assignment, Benefit Plan descriptions and coverage periods will be returned.

The Eligibility Verification and Service Limits selection screen allows detailed searching for enrollee eligibility and service limits.

If service limits are desired, the service limit type must be selected on the Eligibility Benefit Verification and Services Limits Screen from the service type code drop down box, in addition to the enrollee-specific selection defined in the previous paragraph.

Service Limits Response Screen: For a specific service type code, the quantity remaining and the span of time for the services are provided. When the service limit has been reached, the quantity remaining will be zero. If no services have been used, the full amount allowed will be displayed.

Service limits that may be selected are:

DMAS Values	**HIPAA Standard Values**
Substance Abuse	AI – Substance Abuse
42 – Home Health Care (Home Health Aide)	
43 – Home Health Visits (Skilled Nursing)	
Occupational Therapy	AD – Occupational Therapy
Physical Therapy	AE – Physical Medicine

Speech Therapy	AF – Speech Therapy
Outpatient Psych	A8 – Psychiatric – Outpatient

4. Claims Status Verification Input Screen: Enter either the ICN or the Enrollee ID and service dates in the mm, dd, yyyy format. If the provider number for billing is different than the provider number originally used during logon, then enter the 9-digit Provider ID the claim was billed under.

The additional fields are display-only. Do not enter any data into the remaining fields. The provider information will be populated and returned based on the initial Provider ID entered at login.

Submission of this screen returns the Claims Status Verification Response Screen.

5. Prior Authorization Log Input Screen: The Prior Authorization Log screen audits and researches previously generated Prior Authorizations. Enter either the enrollee ID or one of two other identifying data elements. Always enter both the "from" date of service and the "through" date of service, even if the span is a single day.

Enter either the PA Number or the Procedure Code.

Submission of this screen returns the Prior Authorization Log response screen with data selected from the Prior Authorization Log search screen.

6. Provider Check Log Input Screen: Enter the remittance date in the mm, dd, yyyy format. If a valid remittance date is not entered, all transactions from the last six months will be returned on the response screen.

Submission of this screen returns the Provider Check Log response screen with the transaction type, check or EFT number, payment amount and remit date.

7. Prescribing Provider ID Lookup/Response: This screen is available to pharmacy providers only. Enter the license number for the prescribing provider.

Submission of this screen returns the Prescribing Provider ID Lookup Response screen.

8. Exit Screen: The Exit screen is returned when the Exit button is selected. The application is ended when this screen is invoked.

CITY/COUNTY CODES

(The Three-Digit Numerical Identifier
of the Local Social Services/Welfare Agency Currently Handling the Case)

If two or more recipient records using the same SSN are active on the same date of service, inquirers are prompted to contact the Social Services agency for resolution.

COUNTIES

001	Accomack	087	Henrico	177	Spotsylvania
003	Albemarle	089	Henry	179	Stafford
005	Alleghany	091	Highland	181	Surry
007	Amelia	093	Isle of Wight	183	Sussex
009	Amherst	095	James City	185	Tazewell
011	Appomattox	097	King and Queen	187	Warren
013	Arlington	099	King George	191	Washington
015	Augusta	101	King William	193	Westmoreland
017	Bath	103	Lancaster	195	Wise
019	Bedford	105	Lee	197	Wythe
021	Bland	107	Loudoun	199	York
023	Botetourt	109	Louisa		
025	Brunswick	111	Lunenburg		
027	Buchanan	113	Madison		
029	Buckingham	115	Mathews		
031	Campbell	117	Mecklenburg		
033	Caroline	119	Middlesex		
035	Carroll	121	Montgomery		
036	Charles City	125	Nelson		
037	Charlotte	127	New Kent		
041	Chesterfield	131	Northampton		
043	Clarke	133	Northumberland		
045	Craig	135	Nottoway		
047	Culpeper	137	Orange		
049	Cumberland	139	Page		
051	Dickenson	141	Patrick		
053	Dinwiddie	143	Pittsylvania		
057	Essex	145	Powhatan		
059	Fairfax	147	Prince Edward		
061	Fauquier	149	Prince George		
063	Floyd	153	Prince William		
065	Fluvanna	155	Pulaski		
067	Franklin	157	Rappahannock		
069	Frederick	159	Richmond		
071	Giles	161	Roanoke		
073	Gloucester	163	Rockbridge Area		
075	Goochland	165	Rockingham		
077	Grayson	167	Russell		
079	Greene	169	Scott		
081	Greensville	171	Shenandoah		
083	Halifax	173	Smyth		
085	Hanover	175	Southampton		

CITIES

510	Alexandria	683	Manassas
515	Bedford	685	Manassas Park
520	Bristol	690	Martinsville
530	Buena Vista	700	Newport News
540	Charlottesville	710	Norfolk
550	Chesapeake	720	Norton
560	Clifton Forge	730	Petersburg
570	Colonial Heights	735	Poquoson
580	Covington	740	Portsmouth
590	Danville	750	Radford
595	Emporia	760	Richmond
600	Fairfax	770	Roanoke
610	Falls Church	775	Salem
620	Franklin	780	South Boston
630	Fredericksburg	790	Staunton
640	Galax	800	Suffolk
650	Hampton	810	Virginia Beach
660	Harrisonburg	820	Waynesboro
670	Hopewell	830	Williamsburg
678	Lexington	840	Winchester
680	Lynchburg	976	Central Processing Unit for FAMIS

STATE MENTAL HEALTH FACILITIES

983	Southern Virginia Mental Health Institute
984	Southwestern Virginia Training Center
985	Southeastern State Hospital
986	Northern Virginia Training Center
987	Virginia Treatment Center
988	Northern Virginia Mental Health Institute
989	Southside Virginia Training Center
990	Central Virginia Training Center
991	Western State Hospital
992	Southwestern State Hospital
993	Piedmont State Hospital
994	Eastern State Hospital
995	DeJarnette Sanatorium
996	Hiram Davis Hospital
997	Catawba State Hospital
998	Blue Ridge Sanatorium

CLIENT MEDICAL MANAGEMENT

INTRODUCTION

The Client Medical Management Program (CMM) for recipients and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM recipient and provider restriction procedures is established through federal regulations in 42 CFR 431.54(e-f) and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30-130-820.

RECIPIENT RESTRICTION

Utilization Review and Case Management

Federal regulations allow states to restrict recipients to designated providers when the recipients have utilized services at a frequency or amount that is not medically necessary. Restricted recipients are identified and managed by the Recipient Monitoring Unit (RMU) in the Program Integrity Section of DMAS.

CMM enrollment is based upon review of the individual recipient's utilization patterns and is not to be confused with the MEDALLION program that automatically assigns eligible groups of recipients to primary care providers for primary case management. All Medicaid recipients except MCO enrollees and institutionalized long-term care residents are eligible for utilization review by RMU staff. If the recipient's utilization patterns meet the criteria for enrollment in CMM, the recipient is notified to select designated primary providers. Examples of inappropriate utilization are:

- Emergency room use for medical problems that could be treated in a physician's office;
- Using more than one physician and/or pharmacy to receive the same or similar medical treatment or prescriptions; and
- Inappropriate use of Medicaid transportation services.

Each CMM recipient is assigned a case manager in the Recipient Monitoring Unit to assist both recipients and providers with problems and questions related to CMM. The case manager is available to:

- Resolve case problems related to CMM procedures and provider assignments;
- Counsel the recipient on the appropriate use of health care;
- Approve/deny requests for provider changes; and
- Complete a utilization review prior to the end of the enrollment period to determine if CMM restriction should be extended.
-

Recipient Enrollment Procedures

Recipients identified for CMM enrollment receive a letter explaining the recipient/provider relationships under medical management. The letter includes the Recipient/Primary Provider Agreement forms (see the sample forms at the end of this section) with directions for completing and returning the form to the Recipient Monitoring Unit. Recipients are given thirty (30) days to select their primary providers by obtaining their signatures on the form. The provider's signature indicates agreement to participate as the CMM provider for the recipient. DMAS reviews recipient requests for specific providers for appropriateness and to ensure recipient accessibility to all required medical services.

Recipients also have thirty (30) days from the receipt of the restriction notice to appeal enrollment in CMM. Assignment to designated providers is not implemented during the appeal process.

CMM enrollment is for 36 months. Assignment to both a physician and pharmacy is made with few exceptions. Recipients with dual eligibility for Medicaid and Medicare may be enrolled with only a pharmacy restriction since Medicare is the primary insurance for physician services.

When recipients do not return choices to the Recipient Monitoring Unit or have difficulty in finding providers, RMU staff will select providers for them. RMU staff contact providers directly to request participation as a CMM provider for the recipient and follow-up by mailing or faxing the agreement form for the provider's signature.

When completed agreement forms are received, the recipient is enrolled in CMM effective the first of the next month in which a restricted Medicaid card can be generated. Both recipients and selected providers are notified by mail of the enrollment date.

Recipients enrolled in the Client Medical Management can be identified through the process of eligibility verification. A swipe of the Medicaid ID card will return the names and telephone numbers of the primary care physician and designated pharmacy. The dates of assignment to each provider are also included. This information is also available through the MediCall System and the web-based Automated Response System (ARS). Instructions for both resources are provided in this chapter.

Each CMM recipient also receives an individual Medicaid coverage letter with the name(s) and address of the designated primary health care provider and/or designated pharmacy printed on the front each time there is a change in providers.

Designated Primary Care Physicians (PCP)

Any physician enrolled in Medicaid as an individual practitioner may serve as a designated primary care physician (PCP) except when:

- The physician's practice is limited to the delivery of emergency room services; or
- The physician has been notified by DMAS that he or she may not serve as a designated provider, covering provider, or referral provider for restricted recipients.

Federally Qualified Community Health Centers (FQHCs) and Rural Health Clinics (RHCs) may serve as PCPs also. Other provider types such as ambulatory care centers may be established as designated providers as needed but only with the approval of DMAS.

Primary care physicians are responsible for coordinating routine medical care and making referrals to specialists as necessary. The PCP must arrange 24-hour coverage when they are not available and explain to their assigned recipients all procedures to follow when the office is closed or when there is an urgent or emergency situation.

The provider's *Medicaid provider number* is used for billing and referral purposes.

Designated Pharmacies

Any pharmacy enrolled as a community pharmacy billing on the Pharmacy Claim Form or other acceptable media may serve as a designated pharmacy unless the pharmacy has been notified by DMAS that it may not serve as a designated provider.

Designated pharmacies must monitor the recipient's drug regimen. The pharmacist should fill prescriptions from the PCP, referred physicians, and emergency prescriptions. Referrals can be confirmed by reviewing the recipient's copy of the referral form or by contacting the PCP's office. Close coordination between the PCP and the pharmacist, particularly if a medication problem has been identified, is a very important component of the program.

Changing Designated CMM Providers

The recipient or designated provider may initiate a request for a change of a designated provider by contacting the Recipient Monitoring Unit. Designated providers requesting a change must notify the recipient in addition to contacting RMU. If the designated provider requests the change and the recipient does not select a new provider by the established deadline, RMU shall select for them.

All changes must be preauthorized by DMAS RMU staff. The recipient's RMU case manager may contact the provider before making a final decision on the change request to try to resolve questions or issues and avoid unnecessary changes. If DMAS denies a recipient's request, the recipient shall be notified in writing and given the right to appeal the decision. Changes are allowed for:

1. Relocation of the recipient or provider;
2. Inability of the designated provider to meet the routine medical/pharmaceutical needs of the recipient; or
3. Breakdown of the relationship between the provider and recipient.

Provider changes can occur any time of the month because the effective date is the date the new provider signs the Recipient/Primary Provider Agreement form. When a new provider is assigned, RMU mails a letter to the recipient confirming the effective date of the change. The letter instructs the recipient *to show the letter with the Medicaid identification card.* Letters go to the affected providers also. All verification inquiries will return the new primary provider from the date it is entered into the computer system.

A PCP No Longer in Practice

If a provider leaves the practice or retires, he or she must notify CMM so that the restricted recipient can be reassigned to a new PCP.

Changes in the Designated Provider's Medicaid ID Number

If a designated provider receives a new Medicaid ID number, he or she must notify the CMM staff prior to the effective date of the change if CMM recipients are to be reassigned to the new number.

Covered Services and Limitations

Under CMM, DMAS will pay for covered outpatient medical and/or pharmaceutical services only when they are provided (1) by the designated providers, (2) by physicians seen on written referral from the PCP, (3) by covering providers linked with the designated provider in a CMM Affiliation Group, or (4) in a medical emergency. A medical emergency means that a delay in obtaining treatment may cause death or serious impairment of the health of the recipient. Payment for covered outpatient services will be denied in all other instances (unless the covered services are excluded from Client Medical Management Program requirements), and the recipient may be billed for the services.

All services should be coordinated with the designated provider. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for

reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

Physician Services

A Medicaid-enrolled physician who is not the PCP may provide and be paid for outpatient services to these recipients only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the recipient.
- On written referral from the PCP using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.
- When they are a part of a CMM provider affiliation group that includes the PCP.
- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

Services Excluded from PCP Referral

These services should be coordinated with the primary health care provider whose name appears on the recipient's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program.

Covered services that do not need a referral include:

- Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) well-child exams and screenings (recipients under age 21);
- Immunizations (recipient under age 21);
- Family planning services;
- Expanded prenatal services, including prenatal group education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants;
- Dental services (recipients under age 21);
- Services provided under Home and Community-Based Care Waivered Services;
- Hospice services;
- Renal dialysis services;
- Routine vision care services (routine diagnostic exams for recipients of all ages and eyeglasses for recipients under age 21). Medical treatment for diseases of the eye and its appendages still requires a written referral;
- Audiology services;
- Podiatry services;
- Prosthetic services;

- MH/MR community rehabilitative services;
- Psychiatric diagnostic and therapeutic services (limited sessions of outpatient treatment);
- Inpatient hospital services;
- Life-threatening medical emergencies; and
- School-based services.

CMM Provider Affiliation Groups

Physician affiliation groups allow covering physicians to see each other's patients without a written referral. CMM affiliations may be set up for physicians within a practice or for the single practitioner who arranges coverage by a physician not sharing office space. Affiliations can be open-ended or for a specified period of time (such as when the PCP is away form the office for days or weeks). CMM affiliations may include physicians, Rural Health Clinics, Federally Qualified Health Clinics (FQHC), and nurse practitioners.

Affiliations are not recipient-specific. This means that once provider numbers are affiliated, claims will pay for all CMM recipients who receive services from a member of an affiliation group that includes the recipient's PCP on the date of service.

The PCP requests affiliation by completing the CMM Provider Affiliation Form (see sample form at the end of this section) and returning it to the Recipient Monitoring Unit (RMU). The form is used to set up a new affiliation group or to update a group. Providers are responsible for notifying DMAS when a new provider joins the group or a provider leaves the group to ensure claims are processed correctly. Contact the Recipient Monitoring Unit at (804) 786-6548 in Richmond, or toll-free at 1-888-323-0589, to request a form.

Emergency Room Services

Outpatient hospital emergency room services for restricted recipients are limited to reimbursement for medical emergencies. Emergency hospital services means that the threat to the life or health of the recipient necessitates the use of the most accessible hospital facility available that is equipped to furnish the services. Reimbursement may be conditional upon the review of the emergency-related diagnosis or trauma ICD-9-CM diagnosis codes and the necessary documentation supporting the need for emergency services. Additional guidelines for payment of medical services provided in the outpatient hospital emergency room setting are listed in Chapter IV "Covered Services" in this manual.

CMM clients must have a written PCP referral in order for non-emergency services provided in the emergency room to be reimbursed at an all-inclusive rate. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become non-covered services, and the recipient is responsible for the full cost of the emergency room visit.

CMM also requires a PCP referral form for:

- Reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting, and
- Reimbursement for any follow-up outpatient or office consultations resulting

from an ER visit.

Emergency Pharmacy Services

Prescriptions may be filled by a non-designated pharmacy only in emergency situations (e.g., insulin or cardiac medications) when the designated pharmacy is closed or the designated pharmacy does not stock or is unable to obtain the drug.

Provider Reimbursement and Billing Instructions

Management Fees

Each physician, FQHC, or Rural Health Clinic that serves as a CMM primary care provider (PCP) receives a monthly case management fee of $5.00 for each assigned CMM recipient. Payment is made through a monthly remittance process modeled after procedures for payment of the MEDALLION management fees. PCPs receive a monthly report listing the CMM recipients assigned the previous month for whom payment is made.

PCP and Designated Pharmacy Providers

DMAS pays for services rendered to CMM recipients through the existing fee-for-service methodology. Designated providers (PCP's and pharmacies) bill Medicaid in the usual manner, but non-designated providers who are not affiliated with the CMM provider must follow special billing instructions. Complete instructions for the CMS 1500 (12-90) and UB-92 billing invoices as well as Point-of-Sale (POS) billing can be found in the billing instruction chapter of this manual.

Affiliated Providers

Providers who are affiliated with a designated CMM provider in the Medicaid system bill Medicaid in the usual manner with no special billing instructions. Claims process with a look-up to the CMM Affiliation Groups in the system.

Referral Providers

To receive payment for their services, referral providers authorized by the client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PCP in Locator 17a (I.D. Number of Referring Physician) of the HCFA-1500 (12-90) and attach the Practitioner Referral Form. Write "Attachment" in Locator 10d.

Physicians Billing Emergency Room Services

When billing for emergency room services on the CMS-1500, the attending physician bills evaluation and management services with CPT codes 99281-99285 and enters "1" in Block 24-I. When the PCP has referred the client to the emergency room, place the PCP's Medicaid identification number in Block 17a on the CMS -1500 and attach the Practitioner Referral form. Write "Attachment" in Block 10d.

Facilities Billing Emergency Room Services with a Referral

When billing for emergency room services on the on the UB-92 CMS 14-50, place the PCP's Medicaid identification number in space 83A, and attach the Practitioner Referral Form.

Non-designated Pharmacy Providers

When billing on the Pharmacy Claim Form or as a Point-Of-Sale (POS) provider, enter code "03" in the "Level of Service" field to indicate emergency.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Section
Division of Cost Settlement and Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

PROVIDER RESTRICTION

Restricted providers are identified and managed by the DMAS Provider Review Unit. States may restrict providers from participation in the Medicaid Program when the provider has provided items or services at a frequency or amount not medically necessary or has provided items or services of a quality that does not meet professionally recognized standards of health care. State regulations allow DMAS to restrict providers' participation as designated providers, referral providers, or covering providers for CMM restricted recipients when a provider has billed services at a frequency or level exceeding that which is medically necessary or when a provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.

Provider restriction is for 24 months. Providers may appeal any proposed restriction in accordance with the *Code of Virginia*, Section 2.2-4000 et seq., as discussed in the chapter containing utilization review and control information in this manual. Restriction is not implemented pending the result of a timely appeal request.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

____ Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days) _____

_____

____ See one time only for _____

____ See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter in your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____
Signature of Primary Health Care Provider

_____
Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

_____

_____

Telephone #: (____) _____

(Instructions on Back)

DMAS-70 4/89

REFERRAL PHYSICIAN'S COPY

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLIENT MEDICAL MANAGEMENT PROGRAM
RECIPIENT/PRIMARY PROVIDER AGREEMENT

PHYSICIAN

DATE: _____

RECIPIENT NAME:_____**DMAS#**: _____

I. My choice for primary physician is given below. I understand that Medicaid will pay for covered outpatient physician services provided by my primary physician. Other physicians will be paid only when my primary physician makes a medical referral or is unable to provide services in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ **DATE**: _____

TELEPHONE NUMBER: _(___)_____

II. PRINT NAME AND ADDRESS OF PHYSICIAN: _____

_____

I agree to undertake primary health care and make appropriate referrals to specialists for the recipient named above.

PHYSICIAN'S SIGNATURE: _____ **DATE**: _____

PHYSICIAN'S DMAS ID#: _____ **TELEPHONE NUMBER**: _(____)_____
(Use Virginia Medicaid Provider Billing Number)

MAIL/FAX BY _____ **TO:** _____

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.

2. The physician you select must be enrolled as an individual physician with Medicaid and bill on the HCFA 1500 invoice or other acceptable media using his/her own Medicaid provider number. The physician can tell you if these requirements are met.

3. If the physician agrees to be your primary physician, ask him/her to **sign and date the form and write in the Medicaid provider number.**

4. Be sure the physician's name and the office address are **PRINTED** clearly in Section II.

5. When Sections I and II are completed, return the form to our office in the enclosed postage paid envelope. The form may also be **FAXED** to **(804) 371-8891.**

6. Any questions can be directed to the Recipient Monitoring Unit in Richmond, **(804) 786-6548** or toll free **1-888-323-0589**.

(03/03)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLIENT MEDICAL MANAGEMENT PROGRAM
RECIPIENT/PRIMARY PROVIDER AGREEMENT

PHARMACY

DATE: _____

RECIPIENT NAME:_____**DMAS#:** _____

I. My choice for designated pharmacy is given below. I understand that Medicaid will pay for covered outpatient pharmacy services from my designated pharmacy. Other pharmacies will be paid only when my designated pharmacy does not stock or cannot supply medications in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ **DATE**: _____

TELEPHONE NUMBER: (___) _____

II. PRINT NAME AND ADDRESS OF PHARMACY:_____

_____

I agree to monitor the drug utilization and provide all outpatient pharmaceutical needs for the recipient named above.

PHARMACY REPRESENTATIVE'S SIGNATURE: _____**DATE:** _____

PHARMACY'S DMAS ID#: _____ **TELEPHONE NUMBER**: _____
(Use Virginia Medicaid Provider Billing Number)

MAIL/FAX BY _____ **TO:** _____

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.

2. The community pharmacy you select must be a Medicaid provider that bills on the Pharmacy Claim Form or other acceptable media. The pharmacist can tell you if the pharmacy meets these requirements.

3. If the pharmacist agrees to be your designated provider, ask him/her to **sign and date the form and write in the pharmacy's Medicaid provider number.**

4. Be sure the name and address of the pharmacy is **PRINTED** clearly in Section II.

5. When Section I and II are completed, return the form to our office in the enclosed postage paid envelope. The form may also be **FAXED** to **(804) 371-8891.**

6. Any questions can be directed to the Recipient Monitoring Unit in Richmond. Call toll-free to the CMM Helpline **(1-888-323-0589)** or call **(804) 786-6548** in the Richmond Metro area**.**

SECTION I: General Information

Provider Name: _____ **Provider Number:** _____

Business Name: _____ **IRS ID number** _____

Street Address*:** _____ **Contact Person:** _____

Telephone Numbers: _____ **Contact Phone**: _____

24-hour Access: **(Required)** _____ **Email:** _____

Office Hours: _____ **FAX:** _____

(*The address *must* be a physical street address.)**

SECTION II: Service Locations

Please list all Medicaid provider identification numbers issued to you.

Medicaid Number	**Medicaid Number**
_____	_____
_____	_____
_____	_____

SECTION III: Affiliations

Please list the names and Medicaid numbers of those associated physicians or nurse practitioners at the location listed in Section I who are to be affiliated for business and billing purposes. Use the back of this form if more space is needed.

Name	**Medicaid Number**
_____	_____
_____	_____
_____	_____
_____	_____

DO NOT WRITE BELOW THIS SPACE

RETURN FORM TO:

Recipient Monitoring Unit
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

Affiliation group to include provider numbers listed in Sections II and III.

OFFICE USE ONLY

Affiliation Group number assigned by system ☐

FIPS Code _____

Affiliation Group Number assigned by RMU _____

RMU Signature _____

Date _____